

THE GEORGIA CENTER

FACIAL PLASTIC SURGERY AND LASER AESTHETICS

613 PONDER PLACE

EVANS, GA 30809

706.210.2625

FAX 706.210.9882

Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

THE GEORGIA CENTER has developed the following privacy policies:

Uses and Disclosures

Treatment - Your health information may be used by staff members or disclosed to other health care professionals for the purpose of evaluating your health, diagnosing medical conditions, and providing treatment. For example, results of laboratory tests and procedures will be available in your medical record to all health professionals who may provide treatment or who may be consulted by staff members.

Payment - Your health information may be used to seek payment from your health plan, from other sources of coverage such as an automobile insurer, or from credit card companies that you may use to pay for services. For example, your health plan may request and receive information on dates of service, the services provided, and the medical condition being treated.

Health care operations - Your health information may be used as necessary to support the day-to-day activities and management of THE GEORGIA CENTER. For example, information on the services you received may be used to support budgeting and financial reporting, and activities to evaluate and promote quality.

Law enforcement - Your health information may be disclosed to law enforcement agencies without your permission, to support government audits and inspections, to facilitate law enforcement investigations, and to comply with government mandated reporting.

Public health reporting - Your health information may be disclosed to public health agencies as required by law. For example, we are required to report certain communicable diseases to the state's public health department.

Other uses and disclosures require your authorization - Disclosure of your health information or its use for any purpose other than those listed above requires your specific written authorization. If you change your mind after authorizing a use or disclosure of your information you may submit a written revocation of the authorization. However,

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your decision to revoke the authorization will not affect or undo any use or disclosure of information that occurred before you notified us of your decision.

Practice Duties

We are required by law to maintain the privacy of your protected health information and to provide you with this notice of privacy practices. We also are required to abide by the privacy policies and practices that are outlined in this notice.

Right to Revise Privacy Practices

As permitted by law, we reserve the right to amend or modify our privacy policies and practices. These changes in our policies and practices may be required by changes in federal and state laws and regulations. Whatever the reason for these revisions, we will provide you with a revised notice on your next office visit. The revised policies and practices will be applied to all protected health information that we maintain.

Authorization for Phone Calls

I authorize the staff of Dr. Achih Chen to call my home or work phone number regarding office appointments and/or surgery information.

I authorize the staff of Dr. Achih Chen to leave a message on my voice mail or telephone recorder regarding office appointments and/or surgery information.

Complaints/Contact Person

If you would like to submit a comment or complaint about our privacy practices, or if you believe that your privacy rights have been violated; you should call the matter to our attention by sending a letter outlining your concerns to:

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Evans, Ga. 30809

You will not be penalized or otherwise retaliated against for filing a complaint.

Expiration Date of Authorization

This authorization is valid for five (5) years from the date of signature unless revoked or terminated by the patient or patient's personal representative.

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Right to Terminate or Revoke Authorization

You may revoke or terminate this authorization by submitting a written revocation to THE GEORGIA CENTER. You should contact the Practice Manager to terminate this authorization.

Acknowledgement Form

I acknowledge receipt of this Notice of Privacy Rights which I have reviewed and given my permission to THE GEORGIA CENTER to use and disclose my health information in accordance with it.

Signature of Patient

Signature of Patient's Representative

Name of Patient (Print or Type)

Relationship of Representative to Patient

Date

Date